Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS43ADC	A. BUILDING _____ B. WING _____	10/16/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SALVATION ARMY CORP	830 EAST LAKE MEAD DRIVE HENDERSON, NV 89015

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
U 000	INITIAL COMMENTS Surveyor: 28264 This Statement of Deficiencies was generated as a result of the State Licensure survey conducted at your facility on 10/16/09. The survey was conducted using Nevada Administrative Code (NAC) 449, Facilities For Care Of Adults During The Day, regulations adopted by the Nevada State Board of Health on June 23, 1986. The facility was licensed for 49 total day care clients. The census at the time of the survey was 26. 15 resident files were reviewed and 13 employee files were reviewed. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The following regulatory deficiencies were identified:	U 000		
U 56 SS=F	449.4072 DIRECTOR AND EMPLOYEES 3. Every employee of the facility: (b) Shall provide the division: (1) upon his initial employment, with the results of a physical examination conducted within the preceding 6 months, or with a copy of his medical records for the preceding 3 years, certified by a physician. This Regulation is not met as evidenced by: Surveyor: 28264 Based on record review sample on 10/16/09, the facility failed to ensure that 12 of 13 employees	U 56		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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U 56	Continued From page 1 complied with NAC 449.4072 regarding a physical examination or with a copy of their medical records for the preceding 3 years, certified by a physician (Employee #1,#2, #3, #4, #5, #6, #7, #9, #10, #11, #12, and #13). Severity: 2 Scope: 3	U 56		
U 57 SS=F	449.4072 DIRECTOR AND EMPLOYEES 3. Every employee of the facility: (b) Shall provide the division: (2) Upon his initial employment, with a negative report of a tuberculin test conducted within the preceding 6 months. Thereafter, a tuberculin test must be completed every 2 years. If the report of the tuberculin test is positive, he shall provide an X-ray film of his chest. This Regulation is not met as evidenced by: Surveyor: 28264 Based on record review sample on 10/16/09, the facility failed to ensure that 8 of 13 employees had evidence of tuberculosis (TB) skin testing within the preceding six month (Employees #2, #3, #4, #5, #7, #8, #10, and #13). Severity: 2 Scope: 3	U 57		
U 85 SS=C	449.4073 Files Concerning Employees A separate file must be maintained and kept current on each employee. The file must include the following: 1. The employee's: (f) Application for employment. This Regulation is not met as evidenced by: Surveyor: 28264 Based on record review sample on 10/16/09, the facility failed to ensure that 12 of 13 employee	U 85		

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U 85	Continued From page 2 files included a copy of an employee application (Employee #1,#2, #3, #4,#6,#7, #8, #9, #10, #11, #12, and #13). Severity: 1 Scope: 3	U 85		